A National Guard Program
Wyoming Cowboy Challenge Academy
Courage To Change

P.O. Box 697
Guernsey, Wyoming 82214
(307) 836-7500

Tammie Kennedy, RN, BSN
Medical Officer/Nurse
(307) 836-7510 Office
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Sports Physical Exam Form

Name:_____ DOB: ___/___/___ Sex: M F

HT:_____inches WT: _____ pounds Temp: _____ Pulse: _____ Resp: _____ B/P: _____

STI exposure: Y N Tanner Scale:_____ Substance Use: _____

Females ONLY: LMP: ____/____/____ Menarche:_____ years old Dysmenorrhea Y N

Vision test: R: _____/_____ L _____/_____ Both _____/_____ ***(It is preferred that cadet have 2 pair of glasses)***

(Note to Parents: If Vision test is 20/20, or better, page 4 is not required)

System	Normal	Initial Normal	Abnormal Findings
General			
MS	FROM all joints; No Pain, Deformity		
EENT	WNL		
Lymph	WNL		
CV	WNL (For Abnormal: cardiac workup prior to clearance)		
Respiratory	WNL		
Abdomen	WNL		
Derm	WNL: No Scabies or Pediculosis		
Genitals	(Males ONLY) WNL		
Neuro	WNL		
Extremities	WNL		

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Current Medications:

_____

_____

_____

Has individual stopped taking prescription medications within the last 3 months? If yes, list medications, reason for taking medication(s) and reason for discontinuing

_____

_____

_____

(please ensure student will have refills for the entire 5 ½ month residency)

Allergies:_____

_____

I have examined the above individual and:

[ ] Declare the individual CLEARED without any restrictions to activity and is ready for entrance into WCCA.

(Cadets will be required to do strenuous physical activity daily, including, but not limited to: running, jumping, push-ups, climb stairs and lift a minimum of 20 lbs.)

[ ] Recommend the individual be followed by a physician for medical reasons (please specify below):

[ ] Restrict physical activity to exclude the following activities (please specify below):

[ ] NOT recommended for entrance into WCCA

_____

_____

_____

Signature and Title of Examiner **Date**

Printed Name and Title **Name of Clinic**

Address

Phone Number **Fax Number**

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Dental Health Verification

This form is to be completed by primary dental provider prior to admission to ensure they are ready and able to participate.
Only previously scheduled and urgent dental issues are permitted during your child's attendance at WCCA. Routine work will be deferred until the post-residency phase.

Name:_____ **DOB: ___/___/___ Sex: M F**

Date of Last Dental Exam: ___/___/___Results:_____

Does the applicant:

Need fillings or extractions that require immediate attention:

_____

_____

Have previous extractions (including wisdom teeth) and date completed:

_____

_____

Have dental conditions in need of urgent attention in the following six (6) months.

_____

_____

List any removable prosthetics or retainers:

_____

_____

Require a night guard or any special mouth care on a daily basis?

_____

_____

Have a TMJ problem?

_____

This applicant WILL / WILL NOT be able to complete a 5 ½ month training program without dental intervention.

_____

Signature and Title of Person Completing this Form **Date**

_____

Printed Name and Title **Name of Clinic**

_____

Address

_____

Phone Number **Fax Number**

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Vision Examination Record

(This page is NOT required if Sports Physical Exam Form states Vision at 20/20, or better)

Name:_____ DOB: ___/___/___ Sex: M F

Examination Results:

_____

Recommendations:

_____

Vision test: R: _____/_____ L _____/_____ Both _____/_____

RX

	Sphere	Cylinder	Axis	Prism	Add	DVA	NVA
O.D.							
O.S.							

(*It is preferred that cadet have 2 pair of glasses)*

_____

Signature and Title of Examiner **Date**

_____

Printed Name and Title **Name of Clinic**

_____

Address

_____

Phone Number **Fax Number**